

# Advance Health Care Directive

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do one or both of these things. It also lets you write down your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or change all or any part of it. You are free to use a different form.

*You have the right to change or revoke this advance health care directive at any time.*

## Part 1 — Power of Attorney for Health Care

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

Name of individual you choose as agent: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_  
(home phone) (work phone)

ALTERNATE AGENT (Optional): If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

Name of individual you choose as alternate agent: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_  
(home phone) (work phone)

SECOND ALTERNATE AGENT (optional): If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Name of individual you choose as second alternate agent: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_  
(home phone) (work phone)

(1.2) AGENT'S AUTHORITY: my agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Add additional sheets if needed.)

(1.3) WHEN AGENT’S AUTHORITY BECOMES EFFECTIVE: My agent’s authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I initial the following line.

If I initial this line, my agent’s authority to make health care decisions for me takes effect immediately. \_\_\_\_\_

(1.4) AGENT’S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.5) AGENT’S POSTDEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

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(Add additional sheets if needed.)

(1.6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in order of designation.

## Part 2 — Instructions for Health Care

If you fill out this part of the form, you may strike out any wording you do not want.

(2.1) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

Choice Not To Prolong Life

- ☐ I do not want my life prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

Choice to Prolong Life

- ☐ I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(2.2) RELIEF FROM PAIN: I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

(2.3) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that :

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(Add additional sheets if needed.)

### Part 3 — Donation of Organs at Death (Optional)

(3.1) Upon my death (mark applicable box):

☐ I give any needed organs, tissues, or parts, OR

☐ I give the following organs, tissues or parts only: \_\_\_\_\_

My gift is for the following purposes (strike out any of the following you do not want):

Transplant

Therapy

Research

Education

### Part 4 — Primary Physician (Optional)

(4.1) I designate the following physician as my primary physician:

Name of Physician \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

OPTIONAL: If the physician I have designated above is not willing, able or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

Name of Physician \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

### Part 5 — Signature

(5.1) EFFECT OF A COPY: A copy of this form has the same effect as the original.

(5.2) SIGNATURE: Sign and date the form here: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

(5.3) STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence (2) that the individual signed or acknowledged this advance directive in my presence (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly nor an employee of an operator of a residential care facility for the elderly.

#### **FIRST WITNESS**

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

Date: \_\_\_\_\_

#### **SECOND WITNESS**

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

Date: \_\_\_\_\_

(5.4) ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate on his or her death under a will now existing or by operation of law.

Signature of Witness: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

### **Part 6 — Special Witness Requirement**

(6.1) The following statement is required only if you are a patient in a skilled nursing facility — a health care facility that provides the following services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing on an extended basis. The patient advocate or ombudsman must sign the following statement:

#### **STATEMENT OF PATIENT ADVOCATE OF OMBUDSMAN**

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by section 4675 of the Probate Code:

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

Date: \_\_\_\_\_